TRUCKEE TAHOE MEDICAL GROUP

Comprehensive Exam

Age ____ Birthdate: _____

Patient to complete first two pages

Best Phone #: _____

Past Medical History

❑ No known drug allergies Allergies:_____

Past Medical/Psych Problems (diagnosis & date)

_____
_____
_____
_____
_____

Surgeries (give date) _____
_____
_____
_____

Medications (include supplements & vitamins)

	Name	Dose	Times of Day	Since When
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

Further Medical History *(please check if you have had any of the following:)*

- ☐ Stroke
- ☐ Epilepsy
- ☐ Migraines
- ☐ Depression/Anxiety
- ☐ Glaucoma
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Asthma
- ☐ Emphysema, COPD
- ☐ Sleep Apnea
- ☐ TB (Tuberculosis)
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Ulcers
- ☐ Esoph Reflux
- ☐ Diverticulitis
- ☐ Pancreatitis
- ☐ Hepatitis
- ☐ Gallstones
- ☐ Hemorrhoids
- ☐ Kidney Stones
- ☐ Cancer _____
- ☐ Skin Disorders/Cancers
- ☐ Arthritis
- ☐ Gout
- ☐ Bleeding problems
- ☐ Blood clots
- ☐ Blood transfusions
- ☐ Anemia
- ☐ Alcoholism
- ☐ Drug Dependency
- ☐ Chlamydia/Gonorrhea
- ☐ Genital Herpes
- ☐ HIV

WOMEN:
No. of Pregnancies: _____
No. of Deliveries: _____
☐ Ever had abnormal Pap smear? Age ____
Last Menstrual Period Date: _____ (or Menopause?)
Using contraception now?
_____

Habits:
Do you Smoke or Chew Tobacco?
☐ Yes: How many?_____
Since when? _____
☐ I quit _____ years ago.
I smoked for _____ years.
☐ I have never smoked.

How often do you drink Alcohol? How much per day or week?
_____
_____
Do you use other recreational drugs? If so, what type:
_____

Immunizations:
(Note year received)

___Tetanus / Pertussis

___Flu

___Pneumovax

___ Hep B ___Hep A

___Measles, Mumps,Rubella

___Chicken Pox
(or had disease?_____)

___Zoster (Shingles)

With whom do you live? (please give names, ages, relationship)

_____

Type of work / Occupation? _____

What are your exercise habits? Type, Duration, Times per week

_____

What are your eating habits? Note # of servings Fruit/Veggies
Breakfast_____ Lunch _____ Dinner_____ _

Have you traveled recently? Where? _____

Screening Tests: (note Year done, if applicable)

_____ Colonoscopy

_____ Mammogram

_____ Pap smear / pelvic exam

_____ PSA / prostate exam

_____ DEXA scan (osteoporosis)

_____ Cholesterol test

Name _____
Date_____ 1/4

Over for notes. Reviewed: _____

Family History:

Does anyone in your family have (or has anyone had) the following diseases? Please write how you are related and approximate age of diagnosis.

- ☐ Heart attacks, stents or bypass surgery at young age (men<55, women<65) _____
- ☐ Stroke _____
- ☐ Hypertension _____
- ☐ High cholesterol _____
- ☐ Diabetes _____
- ☐ Autoimmune or rheumatic diseases _____
- ☐ Cancers (esp. colon, breast, thyroid, ovarian, uterine, prostate, testicular) What type? _____
- ☐ Depression, anxiety or addictions _____
- ☐ Death at a young age (cause?) _____
- ☐ Osteoporosis _____
- ☐ Other _____

Review of Systems

Place a check in the box if you have any of the following symptoms.

General
- ☐ Sleep problems
- ☐ Change in appetite
- ☐ Chills
- ☐ Fatigue
- ☐ Night sweats
- ☐ Change in weight
- ☐ Fever
- ☐ Bone pain / ache

Skin
- ☐ Mole size/color change
- ☐ Itching
- ☐ Rashes
- ☐ Bruising / bleeding

Neurologic
- ☐ Headache
- ☐ Dizziness / vertigo
- ☐ Fainting
- ☐ Numbness
- ☐ Weakness
- ☐ Tremor
- ☐ Seizure
- ☐ Memory loss
- ☐ Problems concentrating
- ☐ Off-balance

Head and Neck
- ☐ Vision changes
- ☐ Hearing difficulty / changes
- ☐ Taste changes
- ☐ Nose congestion
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Ringing in ears
- ☐ Sore throat
- ☐ Eye pain
- ☐ Hoarseness / voice change
- ☐ Mouth dryness
- ☐ Swelling in neck
- ☐ Neck pain

Endocrine
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Sensitive to heat/cold
- ☐ Nipple discharge
- ☐ Breast lumps
- ☐ Testicle lumps
- ☐ Hair/skin changes

Cardiovascular
- ☐ Chest pain/tightness
- ☐ Short of breath with exertion
- ☐ Ache in arms with exertion
- ☐ Short of breath at night
- ☐ Sleep with extra pillows
- ☐ Irregular heart beat
- ☐ Fast heart beat
- ☐ Swelling in legs
- ☐ Leg cramps with walking

Respiratory
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Bloody sputum
- ☐ Pain with breathing

Gastrointestinal
- ☐ Abdominal pain
- ☐ Indigestion / reflux
- ☐ Trouble swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Black, tar-like stools
- ☐ Change in stool
- ☐ Loss of bowel control

Genitourinary
- ☐ Blood in urine
- ☐ Pain/burning with urination
- ☐ Frequent urination
- ☐ Hard to start & stop urinating
- ☐ Loss of bladder control/incontinence
- ☐ Pain during intercourse

Men:
- ☐ Discharge from penis
- ☐ Difficulty with erections

Women:
- ☐ Vaginal discharge
- ☐ Vaginal bleeding
- ☐ Painful cramping
- ☐ Irregular periods

Musculoskeletal
- ☐ Joint Pain
- ☐ Swelling or redness
- ☐ Back pain
- ☐ Muscle aches
- ☐ Discolored fingers/toes
- ☐ Recent injuries

Psychological
- ☐ Feeling depressed
- ☐ Anxious
- ☐ Mood swings
- ☐ Thoughts of harming yourself or others
- ☐ Obsession with weight
- ☐ Binge eating

Reviewed: _____

Name _____

Date_____